



Texas Department of Insurance

Division of Workers' Compensation

Medical Fee Dispute Resolution, MS-48

7551 Metro Center Drive, Suite 100 • Austin, Texas 78744-1645

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MEDICAL FEE DISPUTE RESOLUTION FINDINGS AND DECISION

GENERAL INFORMATION

Requestor Name

FONDREN ORTHOPEDIC GROUP, LLP

Respondent Name

TRAVELERS CASUALTY & SURETY CO

MFDR Tracking Number

M4-17-2021-01

Carrier's Austin Representative

Box Number 05

MFDR Date Received

FEBRUARY 28, 2017

REQUESTOR'S POSITION SUMMARY

Requestor's Position Summary: "On code J1030 we billed that code with two (2) units and it appears that the carrier only paid the provider for one unit. Therefore we would like for your to reprocess this claim base on the number of units and pay additional money due."

Amount in Dispute: \$6.19

RESPONDENT'S POSITION SUMMARY

Respondent's Position Summary: "The Provider contends they are entitled to reimbursement for a second unit of J1030...the documentation supports only a single steroid injection was given, reimbursement is not due for the second unit of this procedure."

Response Submitted By: Travelers

SUMMARY OF FINDINGS

Dates of Service	Disputed Services	Amount In Dispute	Amount Due
September 15, 2016	HCPCS Code J1030	\$6.19	\$0.00

FINDINGS AND DECISION

This medical fee dispute is decided pursuant to Texas Labor Code §413.031 and all applicable, adopted rules of the Texas Department of Insurance, Division of Workers' Compensation.

Background

1. 28 Texas Administrative Code §133.307 sets out the procedures for resolving medical fee disputes.
2. 28 Texas Administrative Code §134.203, effective March 1, 2008, sets the reimbursement guidelines for the disputed service.
3. The explanation of benefits do not list the reason code used as basis for payment.

Issues

Is the requestor entitled to additional reimbursement for HCPCS code J1030?

Findings

28 Texas Administrative Code §134.203(a)(5) states “Medicare payment policies” when used in this section, shall mean reimbursement methodologies, models, and values or weights including its coding, billing, and reporting payment policies as set forth in the Centers for Medicare and Medicaid Services (CMS) payment policies specific to Medicare.”

HCPCS code J1030 is defined as “Injection, methylprednisolone acetate, 40 mg.”

The respondent contends that additional reimbursement is not due because the documentation does not support the two units billed of code J1030.

A review of the medical report finds “A steroid injection was given today.” The report does not indicate that 2 units of code J1030 was administered to the claimant; therefore, reimbursement for the second unit of code J1030 is not supported. As a result, additional reimbursement is not recommended.

Conclusion

For the reasons stated above, the Division finds that the requestor has not established that additional reimbursement is due. As a result, the amount ordered is \$0.00.

ORDER

Based upon the documentation submitted by the parties and in accordance with the provisions of Texas Labor Code §413.031, the Division has determined that the requestor is entitled to \$0.00 reimbursement for the disputed services.

Authorized Signature

Signature

Medical Fee Dispute Resolution Officer

3/28/2017
Date

YOUR RIGHT TO APPEAL

Either party to this medical fee dispute has a right to seek review of this decision in accordance with 28 Texas Administrative Code §133.307, effective May 31, 2012, 37 *Texas Register* 3833, **applicable to disputes filed on or after June 1, 2012.**

A party seeking review must submit a **Request to Schedule a Benefit Review Conference to Appeal a Medical Fee Dispute Decision** (form **DWC045M**) in accordance with the instructions on the form. The request must be received by the Division within **twenty** days of your receipt of this decision. The request may be faxed, mailed or personally delivered to the Division using the contact information listed on the form or to the field office handling the claim.

The party seeking review of the MDR decision shall deliver a copy of the request to all other parties involved in the dispute at the same time the request is filed with the Division. **Please include a copy of the *Medical Fee Dispute Resolution Findings and Decision*** together with any other required information specified in 28 Texas Administrative Code §141.1(d).

Si prefiere hablar con una persona en español acerca de ésta correspondencia, favor de llamar a 512-804-4812.